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ABSTRACT

This study was designed to ascertain, from the empirical evidence available, the common characteristics of successful licensure efforts in the allied health occupations. A pattern of three steps to licensure for health care occupations emerged from the literature. The first step is birth (of a new occupation), often caused by new technology (new hardware) that causes a department to justify the investment by maximization of use. The second step, creation of an association, stems from a need to communicate. The association has the effect of enhancing the status of the profession by establishing the scope of practice and the effect of enhancing income. The third step is regulating the new occupation, which is caused by turf-consciousness as the group strives to keep other groups from performing its activities (regulation). (Those groups that actually achieved licensure had three main characteristics: they fulfilled a social or national need; they had a minimum of four years of college or university schooling leading to a baccalaureate degree; and they were self-policing.) The study suggests that the three steps (birth, organization, regulation) could form a genesis role model enabling an originating occupation to use the successful efforts of other occupations as steps of progress to guide their own efforts. The model can also be used to pilot further research that will define the characteristics a specific occupation should acquire before seeking licensure. (KC)

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ABSTRACT FORM

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The low success rate of numerous allied health occupations' licensure efforts suggests a need for a new tact. This study was designed to ascertain from the empirical evidence available, the common characteristics of successful allied health occupations' licensure efforts.

The pattern of characteristic steps that avail themselves within the history of emerging health care occupations led to the initial idea of forming a model. These steps were formed into an outline and presented to Dr. Edward Griffin, the chairperson of a special interest group of the American Education Research Association. Dr. Griffin explained the credibility of developing a role model and specifically defined the term genesis role model as "the coming into being of a position of a tentative ideational structure". The study formed a three step genesis role model (birth, organization, and regulation) enabling an originating occupation to utilize the successful efforts of other occupations as credable aspirations and/or steps of progress to guide their own efforts. The third step, regulation, is composed of three requirements: fullfillment of social or national need; baccalaureate degree (minimum for licensed practitioner); and self-policing (research).

Allied health occupations gaining licensure before completing the model developed may subject their occupation to a very restrictive form of licensure. This is a direct result of the narrow scope of practice indicitive of a new health occupation and the concomitant minimum degree of competency required in legislation (licensure) to assure the public health, safety, and welfare. The significance of this study lies within the guiding structure and the versatility of the genesis role model to pilot further research that will define the characteristics a specific occupation should acquire before seeking licensure.

HYPOTHESIS

The organizations seeking licensure of allied health personnel may be facilitated by the creation of a role model from the characteristics that comprise existing allied health professions.

The development of a model seems a logical step for allied health personnel organizations to take in facilitating their efforts for licensure. First, the definition of allied health personnel from the United States Code Annotated, and then a definition of an allied health professional will be given. The following step will be to acquire the definition of licensure and the criteria a legislator will ask of an organization seeking to pass a bill for legal recognition. An interlibrary loan to access the publications fo the Council of State Governments should reveal the identical information made available to a legislator. Next a valued opinion obtained in an interview of a research association officer on the definition and value of developing a role model for an organization will be shown. With the picture gained from the previous efforts, a review of some of the literature in a Health Science Library to ascertain if a pattern of characteristics and events lead to the origin of health care occupations is in order. This, along with a computor search utilizing the National Library of Medicines "Medline" will provide an overview of the literature on potential trends allied health personnel will have to consider when forming a model in their quest for licensure. From the information gathered, the intention is to derive a positive conclusion to the hypothesis.

The definition of "Allied Health Personnel", although

a specific term, is often loosely defined or combined with "Allied Health Professional". This is due to a lack of attention to legal detail within the ever changing field of health care. The Allied Health Directory, 11th Edition, (1982) by the American Medical Association is one example. Excluding the underlined words will correct this definition.

> Allied Health Personnel (also Allied Medical Personnel). Includes professional and skilled supporting personnel in the fields of patient care, public health, and health research who assist, supplement or facilitate the work of other health care professionals--particularly the physician--and independent contractors in providing health services. They may use independent judgment, within their areas of competence, as approved by the supervising physician.[1]

For the purposes of this study the following definitions will be adopted:

> The term "allied health personnel" means individuals with training and responsibilities for supporting, complementing, or supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients.[2]

The definition of "allied health professional" is always found to contain the key root word, license. The term "allied health professional" means any licensed health care provider who is not in the medicine (MD), Osteopathy, and denistry, "MOD" group. The Joint Commission on Accreditation of Hos-

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[1]James J. Balija, ed., Allied Health Education Directory (USA: American Medical Association, 11th Edition, 1982), p. 252.

[2]The Public Health and Welfare. U. S. Code Annotated, Title 42, sec. 295h-4. (1982).

pitals (JCAH) applied the term "specified professional personal"[3] to this group of duly licensed practitioners not within the "MOD" group.

Licensing is a process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency required to ensure that the public health, safety, and welfare will be reasonably well protected.[4]

Regulation should meet a public need. The overriding questions that a state must answer when evaluating the need for licensing are: (1) whether the unlicensed practice of an occupation poses a serious risk to the consumers' life, health, and safety or economic well-being; (2) whether potential users of the occupational service can be expected to possess the knowledge needed to properly evaluate the qualifications of those offering services; and (3) whether benefits to the public clearly outweigh any potential harmful effects such as a decrease in the availability of practitioners, higher costs of goods and services, and restrictions on optimum utilization of personnel.[5]

If an occupation is to be licensed, its scope of practice

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[3]Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals (Chicago: Joint Commission on Accreditation of Hospitals, 1982) p. 165.

[4]Benjamin Shimberg and Doug Roederer, Occupational Licensing: Questions a Legislator Should Ask. Lexington: The Council of State Governments, 1978, p. 1.

[5]Ibid., p. 4.

should be coordinated with existing statutes to avoid fragmentation and inefficiency in the delivery of services.

Restrictions imposed by overly broad scope of practice statements stem, in part, from a failure to recognize that many groups within a system (such as the health delivery system) have overlapping functions. When such groups are granted mandatory licensure based on broad scope of practice statements, certain undesirable consequences, such as fragmentation of services, underutilization of manpower, and unnecessary proliferation of occupational categories, are likely to result.[6]

A field becomes fragmented when many discrete specialty groups, each with its own scope of practice statement, obtain licensure. Fragmentation may be signaled when an already licensed group seeks to prevent an emerging group with a different occupational label from sharing the work.

Underutilization occurs when paraprofessionals, medical auxiliaries or groups which combine parts of several already regulated occupations find that their utilization within the delivery system is impeded by jurisdictional conflicts and by prohibitions against the delegation of functions. Such an uncoordinated delivery system forces employers to hire one of each kind of practitioner. The state policy focus should be on competence and efficiency and the avoidance of exclusive allocation of functions to

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[6]Ibid., p. 5.

certain named groups.[7]

Rather than license a new and discrete occupation, the legislature might consider alternatives such as narrowing the overly broad existing definition of scope of practice or including the new group within the definition of competent practitioners.[8]

Dr. Edward Griffin, the chairperson of a Special Interest Group (SIG) of the American Education Research Association explained the creditability of developing a role model and specifically defined the term genesis role model as follows:

> "The development of new organizations, whether planned or spontaneous, will in all eventuality take similar paths. The utilization of previous successful efforts and characteristics in developing a model, in all but the very myriad instances, will expediate success. Thus, the history of similar organizations provides credence to the development of a genesis role model in an organization's efforts to achieve a desired goal. A genesis role model is the coming into being of a position of a tentative ideational structure."[9]

A pattern of characteristic steps present themselves in the orgin of emerging health care occupations. Following are the three major steps with a brief notation of cause or effect.

The first step, "The Birth of a New Occupation" is often caused by new technology (new hardware) which has the effect

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[7]Ibid., p. 6. [8]Ibid., p. 6.

[9]Interview with Dr. Edward M. Griffin, Ferris State College, Big Rapids, Michigan, 6 March 1984.

of causing a department to justify the investment by maximization of use. The next effect is the realization that it is more efficient to have a lower level technician perform the procedure (birth of a new specialty or occupation.)

The second step, "The Creation of an Association" is caused from a need to communicate. This association has the effect of enhancing the status of the profession by establishing the scope of practice and the effect of enhancing income.

The third step is "Regulating the New Occupation" which is caused by turf-consciousness which has the effect of trying to keep other groups from performing their activities (regulation). The feel of a need for regulation is caused by a desire to have the law validate what the group perceives as its unique status and the desire for legal recognition to enable access to government and private third party payers. Within this step it is important to note the groups achieving licensure had three main characteristics. They fullfilled a social or national need, had a minimum of four years of college or university schooling leading to a baccalaureate degree, and were self-policing (research).

New data from Blue Cross and Blue Shield Association survey shows the number of plans offering a home health benefit has risen from 46% of all plans in 1974 to 90% in 1983. This increase shows the greater awareness of the

benefits of home care and its associated cost-savings.[10]

A survey conducted by the National Research Corporation of Lincoln, Nebraska, of 449 hospital administrators revealed the top alternative service offered to be home care. Twenty-five percent now provide home care and another 33% plan to offer the service by the end of July 1984.[11]

Of the forces driving the growth in the home care up, probably the most important include the government and third party payers. This emphasis on home care is based on the cost advantages of home care versus institutional care. A rapid expansion is predicted, with most forecasters projecting 13% to 20% annual rise in home care through 1990.

Medicare/Medicaid costs can be controlled through home care. According to the National Association for Home Care, fiscal year 1982 reveals the average hospital stay cost $350 per day, a nursing facility $57, and a home health care visit $39.[12]

Consumers will act as prudent purchasers of services as health care providers compete on the basis of access, quality and cost.

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[10]"Insurers See Cost Benefits of Home Care", Hospitals 58 (1 March 1984), p. 46.

[11]"Alternative Services", Modern Healthcare 13 (December 1983), p. 105.

[12]"Medicare, Medicaid Cost Controlled Through Home Care", Hospitals 58 (1 March 1984), p. 46.

Computers and telemetry will find increased use in home care allowing increased monitoring and control with lower cost.

Demand for home care is increasing as a result of greater physician acceptance, increased consumer awareness of home care, and broader third party coverage for care at home.

In conclusion, the three step genesis role model (birth, organization, regulation) enables an originating occupation to utilize the successful efforts of other occupations as credable aspirations and/or steps of progress to quide their own efforts. The third step is critical in the formation of a successful genesis role model for licensure. For this century this clearly means the fullfillment of a social and national need of a health care system that is cost efficient. This means the non-institutionalized care of 20th century patients (home care and ambulatory) whenever applicable. The effective genesis role model will address this need by developing the guidelines and essentials necessary to address the needs of their occupation as it will exist in the cost efficient health care team of ambulatory and/or home care. This careful attention of the organization to the needs of the society it serves will correctly answer the most critical legislators questions on licensure, and complete the successful genesis role model. (See Appendix.)

It is important to note that allied health personnel gaining licensure before completing the model developed in

this study may subject their profession to a very restrictive form of licensure. This will be a direct result of the narrow scope of practice indicative of a new health occupation and the concomitant minimum degree of competency required in legislation to assure the public health, safety, and welfare.

APPENDIX

Genesis Role Model

The following is the skeleton for a genesis role model for allied health personnel developed from this study.

I. The Birth of a New Occupation

II. The Creation of an Association

III. Regulating the New Occupation

1. Fullfillment of social or national need
2. Baccalaureate degree (minimum)
3. Self-policing (research)

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